**AUTHORIZATION TO USE / DISCLOSE / DISCUSS HEALTH INFORMATION**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Allergy, Asthma & Immunology Associates to use/disclose/discuss the areas I have identified below with the individuals listed. (Friends and Family Members) I acknowledge with the signing of this form the medical data to be released may include information that is specific to HIV/AIDs, drug and/or alcohol and/or physician’s treatment (if I have checked them), which cannot be release without a separate consent.

***If you choose to restrict disclosure to anyone please indicate if you wish to restrict your PHI***

***I wish to restrict my PHI to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |  |
| --- | --- |
| 1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **(Person Authorized)** | **(Relationship to you)** |

❒ Unlimited access **(Includes all information listed below)**.

❒ Lab, x-ray, operative & procedure reports, hospitalization reports.

❒ Alcohol/Drug treatment

❒ Psychiatric information

❒ HIV/AIDS information

❒ Sexually transmitted diseases

|  |  |
| --- | --- |
| 1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **(Person Authorized)** | **(Relationship to you)** |

❒ Unlimited access **(Includes all information listed below)**.

❒ Lab, x-ray, operative & procedure reports, hospitalization reports.

❒ Alcohol/Drug treatment

❒ Psychiatric information

❒ HIV/AIDS information

❒ Sexually transmitted diseases

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party, or

(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosure already made with your permission. To revoke this authorization, please send a written statement to attention of Privacy Officer, Allergy, Asthma & Immunology Associates, 3645 Madaca Lane, Tampa, FL 33618. This notice should include the full name and relationship of the person you are revoking privileges from, along with your full name, date of birth, current date and signature.

The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

***This authorization will remain in effect unless a stop date Stop Date:***

***is identified or a written notice to revoke is received.***

Signature Date